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EXPRESS SCRIPTS®

## Account History


Please do not press the BACK button in your browser toolbar.

Questions or fields denoted with  are Required. (Requirements may change depending on other values entered or omitted)[Return To Task List](#)


## Express Scripts Final Re-Credentialing

This document has already been e-signed and is read-only.

## General Information


 NCPDP: **5907448**  
(National Council Prescription Drug Program number)

 NPI: **1912251885**  
(National Provider Identifier)

 Federal Tax ID **455238832**  
(no dashes)

 Pharmacy Name: **Omni-One-Med Pharmacy**

 Legal Name: **Omni-One-Med Pharmacy Services, LLC**  
(if different than call name)

 Address **17310 W. Grand Parkway S,  
Ste. E**

 City **Sugar Land**


 State/Province **TX**


 Zip/Postal Code **77479**


 Country **United States**

 Phone Number: **8325545008**

 Is this a landline? ☒ Yes ☐ No

 Fax Number: **8325545009**

 County **FORT BEND**

 How long has pharmacy been  
at this address? **4**  
(# of Years)

# of Months **0**

 Contact Person: **PIC**

## Current Owner

 First Name: **Hemlata**

Middle Initial:

 Last Name: **Kataria**

 Email Address: **licensing@omnionemed.com**

 Are you authorized to sign on  
the owner's behalf? ☒ Yes ☐ No

## Other Individual Authorized to Sign On Owner's Behalf

First Name:

Middle Initial:

Last Name:

Email Address:

**GOVERNMENT  
EXHIBIT  
318  
4:18-CR-368**

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☒ Is mailing address different from physical address? ☒ Yes ☐ No

Mailing Address  
(if different than physical address)

City

State/Province

Zip/Postal Code

Country **United States**

☒ Name to be printed on check: **Omni-One-Med pharmacy**

☒ Is remittance address different from physical and mailing address? ☒ Yes ☐ No

Remittance Address  
(if different than mailing and/or physical address)

City

State/Province

Zip/Postal Code

Country **United States**

List names and license #s of all Pharmacists employed

Pharmacist/Prescriber in Charge:

☒ First: **Hemlata**

Middle:

☒ Last: **Kataria**

☒ License #: **52562**

☒ License Expiration Date: **03/31/2017**

Pharmacist

☒ First Name: **Tharun**

Middle Name:

☒ Last Name: **Phillip**

☒ License #: **53043**

Add Pharmacist

Type of Practice:

Indicate the anticipated percentage of Rx volume in each setting

Practice Types

Total of below categories **MUST equal 100%**

☒ Open Door Retail/Community

☒ Percentage: **92.00**

☒ Closed Door/ Clinic Facility

Percentage: **0.00**

☒ Mail Order

Percentage: **0.00**

☒ Nursing Home/LTC

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Percentage: 0.00

☐ Internet Pharmacy

Percentage: 0.00

☐ Home Infusion

Percentage: 0.00

☐ Self Administered Injectable/Specialty

Percentage: 4.00

☐ Other

Percentage: 4.00

List other: Non sterile compounding

If Mail Order, does the Pharmacy conduct mail order locally, out of state, or both?

☐ Local☐ Out of State

If Internet Pharmacy, does the Pharmacy fill new prescriptions; refill prescriptions or both?

☐ New☐ Refills

Refill % 0.00

**Dispensing Percentages***Total of the below categories does NOT have to equal 100%*☐ Medicaid

Percentage: 0.00

☐ Medicare

Percentage: 30.00

☐ Workers Comp

Percentage: 0.00

☐ 340B

Percentage: 0.00

☐ Compounds

Percentage: 4.00

If the Compounding Percentage  $\geq 5\%$ , does Pharmacy ship to other states?☐ Yes☐ No☐ N/A

If Yes, list states

☐ Dispensing Physician

Percentage: 0.00

**Business Information**

Do you dispense controlled substances?

☐ Yes☐ No<https://www.esiprovider.com/index.jsp?CFID=1148703&CFTOKEN=c6c99a05fbcba41a-6A2601EE-BF07-9EC2-D51727429AE38EBD&action=DataEntry&cmd...>

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	Federal DEA #: <b>FO3539484</b>
	DEA License Expiration Date: <b>12/31/2016</b>
	State Tax ID: <b>32047903235</b>
	State of Incorporation: <b>TX</b>
	Is this pharmacy a Medicaid provider? <input checked="" type="radio"/> Yes <input type="radio"/> No
Medicaid Licenses	Medicaid #: State where Medicaid Number was issued  Add Medicaid Number
	Insurance Carrier: <b>Evanston Insurance Company</b>
	Liability Insurance Expiration Date: <b>11/19/2016</b>
	Software Vendor: <b>PK</b>
	Switch Company: <b>RSI</b>
	Email address:
	Pharmacy Website URL:
	<input checked="" type="checkbox"/> This pharmacy does not have a website
Hours of Operation (hh:mm or h:mm)	<input checked="" type="checkbox"/> Open 24 Hours <input checked="" type="checkbox"/> Monday - Friday 9:00 From: <input checked="" type="radio"/> AM <input type="radio"/> PM To: 5:30 <input checked="" type="radio"/> AM <input type="radio"/> PM <input checked="" type="checkbox"/> Closed Saturday Saturday 9:00 From: <input checked="" type="radio"/> AM <input type="radio"/> PM To: 1:00 <input checked="" type="radio"/> AM <input type="radio"/> PM <input checked="" type="checkbox"/> Closed Sunday Sunday From:: <input checked="" type="radio"/> AM <input type="radio"/> PM To: <input checked="" type="radio"/> AM <input type="radio"/> PM <input checked="" type="checkbox"/> Closed Holidays Holidays From:: <input checked="" type="radio"/> AM <input type="radio"/> PM To: <input checked="" type="radio"/> AM <input type="radio"/> PM
Services Offered	<input checked="" type="checkbox"/> E-Prescribing Vendor

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- ☐ Braille Labeling
- ☐ Emergency Services
- ☐ Handicap Access
- ☐ Drive-Through
- ☐ TTY (Hearing Impaired)
- ☐ Delivery Service
- Mileage: 25
- ☐ Out of State

## Questionnaire Section

- 1 ➤ Is this pharmacy an open-door pharmacy that fills prescriptions for all walk-in customers without restrictions? ☐ Yes ☐ No

*If no, please provide detailed explanation of pharmacy restrictions:*

- 2 ➤ Do you maintain electronic patient profiles? ☐ Yes ☐ No

- 3 ➤ Do you review prescriptions dispensed for drug interactions? ☐ Yes ☐ No

- 4 ➤ Are you currently affiliated with a buying group or co-op other than a PSAO (e.g., GPO)? ☐ Yes ☐ No

*If yes, please list the name(s) of affiliated buying group(s):*

- 5 ➤ Has the pharmacy (or another pharmacy you have owned) been disciplined by a State Board of Pharmacy, government entity or any other regulatory authority (i.e. State or Federal DEA or State Medicaid Department)? ☐ Yes ☐ No

*If yes, please provide explanation of action taken, and attach board order letter, and any other supporting documents from the State Board of Pharmacy, government entity, or other regulatory authority.*

- 6 ➤ Have any of the pharmacists, pharmacy technicians, owner or employee(s) of the pharmacy been disciplined by the State Board of Pharmacy, a government entity, or any other regulatory authority (i.e. State or Federal DEA or State Medicaid Department) in the last 10 years? ☐ Yes ☐ No

*If yes, please provide details and attach letter(s) of disciplinary action.*

- 7 ➤ Presently, or at any time in the last 10 years, has the pharmacy, its owner(s)/principal(s) or any of its pharmacists been the subject of a civil lawsuit or criminal prosecution involving fraud, deceit, deception or a similar offense involving moral turpitude? ☐ Yes ☐ No

*If yes, please provide a detailed explanation:*

- 8 ➤ In the last 10 years, has the pharmacy or any of its ☐ Yes ☐ No

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owners/principals filed for  
bankruptcy, reorganization, or  
made a general assignment in  
favor of creditors?

*If yes, please provide a detailed explanation:*

- 9 ☒ Presently, or at any time in the last 10 years, has the pharmacy, its owner(s)/principal(s), its pharmacists, or any of its employees been suspended or excluded by the Office of Inspector General (OIG) from participating in any federal or state health care program (e.g., Medicare, Medicaid, TRICARE) or by the General Services Administration (GSA) from participating in any government contract/services? ☒ Yes ☐ No

*If yes, please provide detailed explanation including applicable dates:*

- 10 ☒ Have any of the owner(s), member(s)/principals(s), officers, or directors of the Pharmacy owned any other Pharmacy(ies)? ☒ Yes ☐ No

*If yes, please provide a list of the pharmacies, their NCPDP number(s), and the names of the owners, entity member(s)/principal(s), officers and directors:*

Pharmacy Name:

NCPDP:

Owners, entity  
member(s)/principal(s),  
officers and directors:

Add Pharmacy

- 11 ☒ Has the pharmacy ever changed names? ☒ Yes ☐ No

*If yes, please provide a list of the previous name(s), NCPDP number(s) if different, and the date(s) the name changed:*

Previous Name:

NCPDP:

Date:  
(MM/DD/YYYY)

Add Previous Name

- 12 ☒ Has the pharmacy ever undergone a change in ownership? ☒ Yes ☐ No

*If yes, please provide a list of the previous owner's name(s), ownership dates, and NCPDP number(s) if different:*

☒ Previous Owner Name: **Oliver Anosike**

NCPDP:

☒ Date: **01/15/2014**  
(MM/DD/YYYY)

Add Previous Owner

- 13 ☒ In the past three (3) years, has any vendor providing services, supplies or medications to this Pharmacy, been excluded from participation in Federal or state health care program or government contract, or been otherwise subject to any

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restriction by the OIG or other  
state or government agency?

*if yes, please attach detailed explanation including applicable  
dates.*

- 14 ☒ Has the pharmacy obtained any accreditations/certifications (e.g., PCAB, ACHC, The Joint Commission, URAC, VIPPS, etc.)? ☒ Yes ☐ No

*If so, please submit a copy of certification(s).*

- 15 ☒ Does the owner/pharmacist-in-charge currently hold any non-resident state licensure(s)? ☐ Yes ☐ No

*If yes, please submit a copy of license(s).*

- 16 ☒ Does the pharmacy provide sterile compounding medications? ☐ Yes ☐ No

*If yes please provide most current certification document (e.g., PCAB, air flow hood/HIEPA filtration, etc.).*

Indicate all languages other than English spoken by staff within this pharmacy and languages in which prescription drug labels can be provided

- ☒ All Languages listed below
- |                  |                                   |
|------------------|-----------------------------------|
| Arabic           | <input type="checkbox"/> Language |
|                  | <input type="checkbox"/> Label    |
| Armenian         | <input type="checkbox"/> Language |
|                  | <input type="checkbox"/> Label    |
| Cambodian        | <input type="checkbox"/> Language |
|                  | <input type="checkbox"/> Label    |
| Chinese          | <input type="checkbox"/> Language |
|                  | <input type="checkbox"/> Label    |
| Farsi            | <input type="checkbox"/> Language |
|                  | <input type="checkbox"/> Label    |
| French           | <input type="checkbox"/> Language |
|                  | <input type="checkbox"/> Label    |
| Hindi            | <input type="checkbox"/> Language |
|                  | <input type="checkbox"/> Label    |
| Indian           | <input type="checkbox"/> Language |
|                  | <input type="checkbox"/> Label    |
| Japanese         | <input type="checkbox"/> Language |
|                  | <input type="checkbox"/> Label    |
| Korean           | <input type="checkbox"/> Language |
|                  | <input type="checkbox"/> Label    |
| Mandarin Chinese | <input type="checkbox"/> Language |
|                  | <input type="checkbox"/> Label    |
| Russian          | <input type="checkbox"/> Language |

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	<input type="checkbox"/> Label
Spanish	<input type="checkbox"/> Language
	<input type="checkbox"/> Label
Tagalog	<input type="checkbox"/> Language
	<input type="checkbox"/> Label
Vietnamese	<input type="checkbox"/> Language
	<input type="checkbox"/> Label
Other	<input checked="" type="checkbox"/> Language
	<input type="checkbox"/> Label
	<input type="checkbox"/> Other Languages <b>Serbian</b>

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